nsurance, Division of Workers' Compensation
solution, MS-48
Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-06-6327-01
Integra Specialty Group, PA 517 North Carrier Parkway, Ste. G Grand Prairie, TX 75050	DW Injured Da
Respondent Name and Box #: 19 Zurich American Insurance Co.	Emp Insuran

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUM

Requestor's Position Summary: "...The carrier did provide the original response EOB's for the outstanding date of service of 10/03/05. Also, the carrier failed to provide any request for reconsideration response EOB's for the outstanding dates of service of 10/03/05, 10/21/05, 11/03/05, and 11/16/05."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $348.44
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

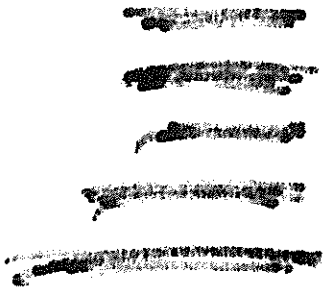
Respondent's Position Summary: "...Requestor's bills were denied on the basis that the conditions being treated were not part of the compensable injury. A contested case hearing was conducted on the extent of injury issue. The decision and order issued November 15, 2005, found that the compensable injury did not include any injury to the right upper extremity in the form of carpal tunnel syndrome, tendonitis, RSD/CRPS, Guyon's canal injury, a TFCC tear, or any injury to the CMC joint. The compensable injury was limited to a right hand contusion. The decision has become final by operation of law."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/03/05	97032, 97035, 97112, 97140, 99213	EOB's not received	1-5	$0.00
10/21/05	95831, 97032, 97035, 97112, 99212	Not listed on the EOB received.	1-5	$0.00
11/03/05	97032, 97035, 97140	Not listed on the EOB received.	1-5	$0.00
11/16/05	97032, 97035, 97112	Not listed on the EOB received.	1-5	$0.00
Total Due:				$0.00



PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202. titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines

1. EOB's were not submitted for the services provided for dates of service as listed in Part IV, Summary of Findings. The Requestor submitted proof of Request for Reconsideration in accordance with Rule 133.307(e)(2)(B).
2. According to the Respondent's position summary the insurance carrier disputed the dates of service as an extent of injury. The Requestor billed using diagnosis code 719.44 – Pain in joint, hand.
3. On November 15, 2005 a Contested Case Hearing was held and according to the decision made by the Hearing Officer, the compensable injury of September 26, 2004 does not include injury to the right upper extremity in the form of carpal tunnel syndrome, tendonitis, RSD/CRPS, Guyon's canal, a TFCC tear, or an injury to a CMC joint. The Hearing Officer also included in the decision that the Claimant had disability, resulting from the compensable injury sustained on September 26, 2004, for the period from September 27, 2004 through October 25, 2004, but not thereafter through the date of the hearing.
4. The Claimant appealed this decision to the Appeals Panel. On February 27, 2006 the Appeals Panel decision affirmed the Hearing Officers decision against the Claimant.
5. Reimbursement cannot be recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

3/7/08

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.